UTAH DEPARTMENT OF HEALTH PRIOR AUTHORIZATION REQUEST FORM

XANAX XR (alprazolam)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX INFORMATION FROM PROGRESS NOTES

CRITERIA:

- Must have failed a 6-8 week trial of oral, short acting alprazolam within the last 6 months

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Phone call from physician or pharmacy